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Public Affairs Office

MEDICARE FACT SHEET

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More Choices, Better Benefits
The Medicare + Choice Program

Background: *The Bush Administration is encouraged by the recent stabilization in Medicare + Choice. The Administration has continued to take aggressive steps to strengthen and improve health plan options for seniors and disabled Americans. More choices, better benefits and greater access to health care are key goals of the Bush Administration's plan to improve and strengthen Medicare by giving people who are covered by Medicare additional and better benefit options, as well as access to affordable prescription drugs. This is especially important for lower-income and minority seniors and disabled individuals who depend the most on Medicare + Choice plans for helping them keep costs affordable for the valuable benefits that are not available in fee-for-service Medicare.*

While the Administration is disappointed to hear about any beneficiaries losing a health plan option, it is pleased to see the program stabilizing in anticipation that Congress will change the program for the better.

The Medicare + Choice program was created by Congress in the Balanced Budget Act (BBA) of 1997. The first Medicare + Choice plans began providing health care services to people served by Medicare in January 1999. Most Health Maintenance Organization (HMO) and Private Fee For Service contracts (PFFS) with the federal Centers for Medicare & Medicaid Services (CMS) operate under the Medicare + Choice program. A Medicare + Choice plan typically provides health care coverage that exceeds the coverage of original fee-for-service Medicare. Currently, of nearly 40 million Americans in Medicare, about 4.6 million (12 percent of all beneficiaries) have chosen to be in a Medicare + Choice plan.

Over the past six years some beneficiaries who enrolled in a Medicare + Choice plan have been affected by their plan's withdrawal from the Medicare program, or a decision by the plan to reduce its service area:

- *For 2004, 16 Medicare + Choice plans withdrew or reduced their service areas (5 plans withdrew and 11 reduced service area) affecting approximately 41,000 beneficiaries (about 0.8 percent of the 4.6 million Medicare + Choice enrollees).*

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- *About 3,100 enrollees were left without any other Medicare + Choice option. As of September 1, there were 9 new plan requests to provide new service and 22 service area expansions pending for CMS approval.*

- *In 2003, 33 plans withdrew or reduced their service areas affecting approximately 217,000 enrollees (about 4 percent of the 5 million current Medicare + Choice enrollees). Of these, 186,710 had another Medicare + Choice option – a coordinated care plan, private fee for service plan or one of the preferred provider demonstration options (PPO). About 28,555 had no other Medicare + Choice option (about 0.5 percent of the 5 million current Medicare + Choice enrollees).*

- *In 2002, 58 Medicare + Choice plans either withdrew (22 contracts) or reduced their service areas (36 contracts) affecting about 536,000 beneficiaries (10 percent of enrollees in Medicare + Choice). About 38,000 had no other Medicare + Choice option.*

- *In 2001, 118 Medicare + Choice plans either withdrew from the Medicare + Choice program (65 contracts) or reduced a service area (53 contracts) affecting about 934,000 people (15 percent of total enrollment in Medicare + Choice). Of these, 159,000 people were left with no other Medicare + Choice option.*

- *In 2000, 90 plans withdrew or reduced their service areas affecting approximately 327,000 enrollees (5 percent of Medicare + Choice enrollees) and 79,000 people (1.3 percent of enrollees) were left with no other plan option.*

- *In 1999, 96 plans withdrew or reduced their service areas affecting approximately 407,000 enrollees (about 6.5 percent of 1998 Medicare + Choice enrollees). About 51,000 of these people (less than one percent of enrollees) were left without any other Medicare + Choice option.*

As private sector managed care companies make business decisions that affect Medicare beneficiaries, CMS continues to undertake a comprehensive outreach effort to educate beneficiaries about their remaining health care options and the rights and protections they are guaranteed by law when a plan leaves Medicare. These options can include other Medicare + Choice organizations such as HMOs, PPOs or private fee for service plans or original fee-for-service Medicare with or without a Medigap policy.

Working with Medicare + Choice Organizations
The Centers for Medicare & Medicaid Services is committed to provide more choices for seniors by reducing the regulatory burden on Medicare + Choice plans.

In 2003, CMS made the following improvements:

- Waived the need for a 3-day hospital stay prior to entering a nursing home. For beneficiaries returning to the original Medicare program during a skilled nursing facility stay, this allows for payment of the stay without the 3-day hospital stay requirement, if the admission to the SNF occurred while the beneficiary was enrolled in a Medicare + Choice plan.

- Provided that Medicare + Choice organizations have the option of using a uniform local coverage policy for a health plan that covers multiple localities. A Medicare + Choice plan that covers more than one geographic area, such as a three State region, can choose which local policy is most beneficial to its enrollees, based on current practice experiences. This allows the plan to standardize coverage decisions and provider contracts across the entire plan.

- Allowed Medicare + Choice organizations to continue to offer extended "visitor" or "traveler" programs to members who have been out of the service area for up to 12 months, as long as the plan includes the full range of services available to other members.

- Allowed plans to await the outcome of an appeal before effectuating a decision by an administrative law judge (ALJ). If a plan intends to appeal a decision by an ALJ, it does not need to implement the ALJ's decision until the Departmental Appeals Board makes its decision.

- Expanded the annual fall advertising campaign to educate beneficiaries about the full range of options open to them. CMS has also enhanced its toll-free telephone help line, 1-800-MEDICARE (1-800-633-4227 or TTY/TDD 1-877-486-2048) with 24-hour service, seven days a week. Additional customer service representatives have been added. They can tailor answers to individualized beneficiary questions and mail a copy of customized information immediately after each call.

Further reducing burden for Medicare + Choice plans

- **Reducing incentive plan reports**. CMS reduced physician incentive plan reporting requirements by no longer requiring annual reports. Reports only need to be submitted upon request.

- **Working aged payment reporting.** CMS created a simplified process to identify working aged beneficiaries. Starting in 2004, CMS will use an annual survey to establish working aged status for the year, rather than requiring individual-level factors that are updated monthly.

- **Consistent quality improvement requirements**. Quality requirements for Medicare + Choice Organizations reflect the best practices requirements of the private sector in 2003. CMS again awarded more than two-thirds of the Medicare + Choice Organizations incentive payments for exceeding the thresholds on two quality indicators for Medicare beneficiaries with congestive heart failure.

- **Emphasis on better results for beneficiaries**. CMS has replaced calendar-driven audits with results-based performance audits so that we target audits at "bad actors." "Good actors" can spend less time with paper and more time with patients.

- **Restricting mid-year changes.** CMS has established a policy of restricting the implementation of significant new requirements mid-year. Any changes in requirements that add cost or burden cannot be implemented until the following calendar year.

- **Quarterly policy changes.** CMS has coordinated policy changes to coincide with contracting cycles and is working to provide quarterly updates in a manual.

Risk adjustment
In improving payments made to Medicare+Choice organizations, CMS has implemented risk adjusted payments in a budget neutral manner. Risk adjustment modifies capitated payments to account for differences in health status among Medicare + Choice enrollees. By implementing risk adjustment in a budget neutral manner, aggregate payments that might have been reduced under risk adjustment are instead redistributed among Medicare + Choice organizations. Implementing risk adjustment in this manner will have the effect of increasing county rates by 4.89 percent in 2004.

National coverage determinations
All national coverage determinations will be bundled to determine if, in combination, they result in a significant cost increase, which will be added to plan payments in the subsequent year. All national coverage determinations and legislative changes in benefits will be added together. If all these changes exceed a "significant" cost threshold, payments are increased.

A Comprehensive Effort to Provide Beneficiaries Affected by Non-Renewals with Accurate Information about Their Remaining Options
CMS continues to work with its partners to provide Medicare beneficiaries affected by non-renewals with accurate information as soon as possible. CMS works to inform beneficiaries through 1-800-MEDICARE (1-800-633-4227), www.medicare.gov, its regional and national offices, State Health Insurance Assistance Programs (SHIP), including some 12,000 trained counselors in 1,000 local organizations administered by the states' insurance departments or departments of aging, and other programs, as well as through the Medicare + Choice Organizations that are withdrawing.

CMS also provides information to public officials including members of federal, state, and local government agencies, members of Congress. CMS works with their questions about education events with insurance counselors to help with their questions about Medicare + Choice plans and Medigap insurance.

CMS also works with the news media to provide information to beneficiaries affected by non-renewals. A key piece of the CMS message is that beneficiaries are still in the Medicare program. They may be able to join another Medicare + Choice plan or they can return to original fee-for-service Medicare. If they return to the original fee-for-service plan, they have a right to buy supplemental insurance policies, known as Medigap policies, on a guaranteed issue basis. A Medigap plan can help pay for some costs not covered by Original Medicare.

Medicare & You 2004 contains basic information about Medicare and plan comparison information and will be mailed to 36 million beneficiaries during October 2003. Information about how to choose and buy a Medigap policy is available in our free publication, the 2003

Guide To Health Insurance for People with Medicare: Choosing a Medigap Policy. (This can be downloaded at www.medicare.gov or ordered by calling 1-800-MEDICARE (1-800-633-4227).

Again this year, CMS will conduct a national advertising campaign, with a special outreach to people with access barriers to information, including language, location and culture. The purpose of the campaign is to acquaint Medicare beneficiaries and their caregivers with easy access to information available on CMS' toll-free telephone help-line, 1-800-MEDICARE (1-800-633-4227), which is staffed 24 hours a day, seven days a week. After the phone call, information can be mailed directly to the beneficiary. Helpful publications can be ordered by calling 1-800-MEDICARE or downloaded at www.medicare.gov.

Partners in CMS' efforts to disseminate information to Medicare beneficiaries include: the Leadership Council of Aging Organizations, the American Association of Health Plans, AARP, the National Council of Senior Citizens, the National Rural Health Association, the National Council on Aging, the National Hispanic Council on Aging, the National Caucus and Center on Black Aged, the Older Women's League, the Social Security Administration, the U.S. Administration on Aging and State Health Insurance Assistance Programs.

Medicare + Choice Organizations' Obligations To Beneficiaries After Non-Renewal
Even after Medicare + Choice Organizations notify CMS of their intention to withdraw for the coming year, certain obligations to enrollees remain. Chief among them is the plan's obligation to provide contracted services through December 31, 2003, when most annual plan contracts expire. Non-renewing plans, or those reducing a service area, are required to send plan members affected by the change an information package by October 2, 2003. This package explains remaining options in their area for health care coverage, including another Medicare + Choice Organization, if available, or Original Medicare, which can be supplemented by a Medigap policy. The package also explains beneficiaries' rights and protections if they choose to return to fee-for-service Medicare and buy a Medigap policy.

CMS reviews and approves the information packages that are sent by plans to Medicare beneficiaries affected by the plan changes. Basically, the letter says that beneficiaries can remain in their plan through December 31, 2003 or they can disenroll before that time and either return to Original Medicare or enroll in another Medicare + Choice plan if available. In general, if no action is taken, they will automatically be disenrolled from their plan after December 31, 2003 and return to original Medicare. For help in selecting their best option, beneficiaries are invited to call 1-800-MEDICARE, or their local SHIP.

Beneficiaries May Have Other Medicare + Choice Options
Other Medicare managed care plans and private fee-for-service plans that operate in the same area as a non-renewing plan are required to be open to accept new enrollments during a Special Election Period from October 1 through December 31, unless they have a CMS-approved capacity limit that has been met. If another plan in a county accepts new members, beneficiaries can select an effective start date of November 1, December 1, or January 1 as long as the new plan receives the completed election form prior to the start date. Beneficiaries who enroll in another Medicare managed care plan or a private fee-for-service plan should not submit a disenrollment form to the non-renewing plan. They will be automatically disenrolled.

Returning To Original Medicare
Beneficiaries who wish to return to Original Medicare should consider whether they need to buy a Medicare supplement (Medigap) policy before they disenroll from their Medicare + Choice plan. A beneficiary can stay enrolled in the Medicare + Choice Organization until December 31, 2003, or voluntarily disenroll and return to Original Medicare before December 31. Each beneficiary is encouraged to get complete information about his or her specific situation in order to protect the right to buy a Medigap plan.

People who wish to leave their Medicare + Choice Organization before December 31, 2003 can call 1-800-MEDICARE (1-800-633-4227) or complete a disenrollment form that is available from their health plans, any Social Security Administration office, Railroad Retirement Board office (for railroad retirees). Buying a Medigap plan does not automatically disenroll a beneficiary from a Medicare + Choice plan.

In general, beneficiaries who do not disenroll will automatically be enrolled in Original Medicare starting January 1, 2004.

Medigap Policies
Beneficiaries whose Medicare + Choice plans leave Medicare have a guaranteed right to buy Medigap Plan A, B, C, or F. Some beneficiaries may have more choices of Medigap policies depending on the length of time they have been in a Medicare managed care plan, or if state law provides additional rights.

Beneficiaries must apply for a Medigap policy no later than 63 days after coverage under their Medicare + Choice plan ends. During this time period, an insurance company that sells Medigap polices must sell the beneficiary a policy and cannot refuse to cover preexisting conditions or charge the beneficiary a higher price for the policy because of past or present health problems.

CAUTION: Beneficiaries should make a copy of their Medicare + Choice Organization's final notification letter (dated October 2) to send with their application for a Medigap policy to show they have a special right to buy a Medigap policy. Beneficiaries should also keep a copy of their Medigap application as proof that they applied for a Medigap plan within the required time period.

Supplemental Coverage For Medicare Beneficiaries Enrolled In An Employer or Union-Sponsored Plan
A beneficiary whose employer, former employer or union has an arrangement with the managed care organization offering the Medicare + Choice plan in which he or she is enrolled is advised to consult with that employer, union or benefits administrator before making plan changes.

Affected Beneficiaries May Be Able To Retain Their Doctors
Beneficiaries who choose to return to Original Medicare will probably be able to continue with many of the doctors they saw in their Medicare + Choice Organization. More than 90 percent of Medicare + Choice doctors participate in Original Medicare, as well as in multiple Medicare + Choice Organizations. To see if a physician participates in Original Medicare (and accepts Medicare assignment) look at the Participating Physician directory at www.medicare.gov.

Information On Other Medicare + Choice Plans and Health Care Options
Current information about other Medicare + Choice plans available in a local area is available at 1-800-MEDICARE (1-800-633-4227 and TTY 1-877-486-2048), and on the web site: www.medicare.gov. Once on the site, click on *Medicare Personal Plan Finder*, and then enter your zip code. (Some Medicare + Choice plans are available only in certain zip codes.) Many libraries and senior centers can also help with web site access and information. Information about Medicare + Choice Organizations available in 2004 will be online October 21, 2003. The *Medicare Personal Plan Finder* tool helps beneficiaries compare the aggregate out-of-pocket costs of available Medicare + Choice options and Medigap policies. For general help understanding health care options, beneficiaries may contact their State Health Insurance Assistance Program. They may also contact the U.S. Administration on Aging's toll-free Eldercare Locator at 1-800-677-1116 (Monday through Friday, 9am – 8pm Eastern time) to be referred to their local Area Agency on Aging.

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